Patient Bill of Rights

FACT SHEET

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Insurance Commissioner

INTENT:

The Legislature intends that patients covered by health plans receive quality care, designed to maintain and improve their health, including sufficient and timely access and adequate choice of health-care providers. The Patient's Bill of Rights (2SSB6199) outlines procedures to ensure that patients:

- Are assured that health-care decisions are made based on appropriate medical standards;
- Have better access to information regarding their health insurance plans;
- Have access to a quick and impartial process for appealing denials of coverage;
- Have the right to independent third-party reviews of denials;
- Are protected from unneeded invasions of their privacy;
- Can seek redress for damages that result when managed care carriers withhold or deny appropriate care.

These provisions took effect on July 1, 2001.

1. Privacy Guarantees

A health carrier is prohibited from releasing personally identifiable health information unless it is authorized in writing, unless it is required to control sexually transmitted diseases, or unless it is covered by existing privacy laws applying to health information. The Insurance Commissioner adopted rules to implement these requirements on January 9, 2001. These rules take effect on July 1,2001 with benefits effective on the policy renewal date.

2. Disclosure of Health Plan Benefits, Including Exclusions

A listing of covered benefits, including prescription-drug coverage, must be disclosed prior to purchase of any health plan. This disclosure must include any exclusion, limitation or reduction in coverage, including any coverage criteria which may be applied when determining what is a covered service. Other items to be disclosed prior to purchase are the carrier's policies to protect confidentiality, premium, and other enrollee costs, a summary of grievance procedures, an explanation of the amount you need to pay for services (i.e. copays, deductibles or

coinsurance) and a convenient means of obtaining a list of participating providers. Additional information describing the plan and its operations must be made available upon the request of a prospective enrollee or a current enrollee.

3. Grievance Procedures

Each health carrier must implement a grievance process under which an enrollee can appeal any denial of coverage. The process must meet standards established by the Insurance Commissioner, as well as meet timelines, notice and due process requirements established in the law. The process must be prompt, fair and impartial, providing timely notice of its results to the enrollee together with notice of other options for alternative treatment, further appeal or independent third party review.

4. Independent Third-Party Review of Appeals

An enrollee whose health coverage has been denied may seek an independent, third-party review, and insurers must develop a process to allow it. The results of this review are binding on the carrier. The Department of Health has adopted rules for certification of review organizations. The Insurance Commissioner has adopted rules for the selection and operation of independent organizations to perform these reviews. The Commissioner is responsible for designating organizations meeting these standards, charging health carriers' fees as needed to fund these organizations, and providing ongoing oversight of the review boards.

5. Redress for Damages that Result from Denial of Care

Health carriers and their employees and agents must follow accepted standards of care when making health care treatment decisions. In the event they fail to follow accepted standards of care, they are liable for damages for harm caused to the consumer. Consumers must exercise the opportunity for independent review prior to suing their carrier, unless they have already been hurt or an independent review is deemed not beneficial to the enrollee.

6. Access to Providers

Health carriers must allow subscribers to choose a primary health care provider from a list of participating providers and allow them to change providers. Carriers must provide prompt and appropriate referrals to specialists. When chiropractic care is covered, subscribers must be allowed direct access to chiropractic care. Subscribers with complex or serious conditions may even receive a standing referral to a specialist.

Consumers needing assistance may contact our toll-free Consumer Hotline at 1-800-562-6900

Need help with an insurance problem or question? The Insurance Commissioner's Consumer Advocacy division has experts in all lines of insurance (auto, homeowner, life, disability and health) who can assist you. Call our toll-free hot line at **1-800-562-6900.**

In addition, if you need help with health insurance issues, Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine is a free service of the Insurance Commissioner's office. SHIBA HelpLine provides specialized health insurance education, assistance, and advocacy, including individualized counseling regarding your rights and options. Call **1-800-397-4422** to be referred locally for assistance.